Massachusetts Division of Health Care Finance and Policy
2 Boylston Street, Boston, MA 02116
Tel (617) 988-3100 FAX (617) 727-7662 TTY (617) 988-3175

NURSING FACILITY OWNERSHIP INFORMATION FORM

I. Facility Information

Vendor Payment Number (VPN)	
Facility Name	
Facility Street Address	
Facility City, State, Zip Code	
Facility Phone Number (voice)	
Facility Phone Number (fax)	
Facility e-mail address	

II. Management Company Information

Are you managed by a management Company? ☐ Yes ☐ No
If you answered "yes", complete the following:

Management Company Name	
Street Address	
City, State, Zip Code	
Phone Number (voice)	
Phone Number (fax)	
E-mail address	
Contact Name	

III. Ownership Information

List all direct and indirect owners with an interest of 5% or more in this facility. See instructions for the definition of "Owner". If you own any other nursing and/or rest home, Section IV must be completed.

Direct (D) or Indirect (I)	Name of Owner	Address (Street, City, State, Zip)	Telephone Number	Fax Number	Email Address	% Share

Attach additional pages if necessary.

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Facility Name _____

IV. Related Facility Information

List the name(s) of any other nursing and/or rest homes in which the owners listed in Section III own, directly or indirectly, an interest of 5% or more.

Facility Name	VPN	Address

Attach additional pages if necessary.

The facility representative whose signature appears below, is acknowledging to the best of his/her knowledge, by said signature, that the information in this worksheet is true, accurate, and prepared in accordance with applicable regulations and instructions under the pains of penalties of perjury.

_____ _____
Signature of Owner, Partner or Officer Date

_____ _____
Print Name of signatory above Print Title